

WOMEN'S CANCER CENTER GYNECOLOGIC ONCOLOGY

Ortenzio Cancer Center
2035 Technology Parkway
Suite 201
Mechanicsburg, PA 17050
717-221-5940

**Fredricksen
Outpatient Center**
2025 Technology Parkway
Suite 109
Mechanicsburg, PA 17050
717-230-3026

**UPMC Community Osteopathic
Medical Sciences Pavilion**
4300 Londonderry Road
Suite 305
Harrisburg, PA 17109
717-221-5940
Every Friday

**Lebanon Valley
Advanced Care Center**
1251 East Main Street
Suite 3
Annville, PA 17003
717-230-3026
2nd Friday of the month

Edward S. Podczaski, MD Sharon Ann-Romano Fitzgerald, MD Mark Miller, DO

Thank you so much for asking us to participate in the care of your patient. We appreciate your confidence in our practice. In order for us to promptly contact your patient and provide her with an appropriate appointment, we ask that you fax to us the following pertinent material that applies to this patient: Recent Progress Notes, Radiology Reports, Pathology Reports, PAP Results, Laboratory Reports, Operative Reports, EKG, Current Medications, Copy of Insurance Cards (both sides)

Please fax all forms to the respective practice

In addition, in order for us to properly document your request, we ask that you write a brief note below. Thank You.

Reason for Referral: _____

Referring Physician (Please Print) _____

Referring Practice Phone # _____ Fax _____

Referring Doctor's NPI # _____ Practice Name _____

Patient's Primary Care Physician _____ Phone # _____
(if not referring provider)

PATIENT NAME _____

Social Security # _____ DOB _____ / _____ / _____

Phone # _____ Work # _____ Cell # _____

Address _____

Primary Insurance _____ Policy # _____ ID # _____

Subscriber _____ Social Security # _____ DOB _____ / _____ / _____

Subscriber's Employer _____

Secondary Insurance _____ Policy # _____ ID # _____

Subscriber _____ Social Security # _____ DOB _____ / _____ / _____

Appointment Date Scheduled _____ Dr. _____

Please retain a copy for your records



WOMEN'S CANCER CENTER REFERRAL FORM



PATIENT IDENTIFICATION